STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF OPERATIONS SUPPORT
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, NH 03301
TDD Access: Relay NH 1-800-735-2964
Agency Phone: 603-271-4592

APPLICATION FOR RESIDENTIAL AND OR HEALTH CARE LICENSE
(LABORATORIES AND COLLECTING STATIONS)

LICENSE #: _____ EXPIRATION DATE: _____

This application shall be filled out in accordance with RSA 151:4. A separate application must be submitted for each licensure category. **Please be sure to complete the entire application**. If a section does not apply to your facility mark not applicable (n/a). Failure to complete the application will result in a delay in the licensure process. Send the completed form to the address above. Check all applicable items:

License renewal:	☐	*New administrator:	☐	*New facility:	☐
**New facility name:	☐	*New owner:	☐	*Change in # of beds:	☐
*Change in classification:	☐	*Change in address:	☐	Other (please explain):	☐

* Requires processing as a new application.
*If a new facility, please submit directions to your location, from Concord, with your application.
** May require processing as a new application.

Licensee: _____ Telephone #: (___)_____
(same name as ownership)
Name of Facility: _____ Telephone #: (___)_____
E-Mail: _____ Fax #: (___)_____
Street Address:_____City:_____State:____Zip:_____
Mailing Address:_____ City:_____State:____Zip:_____
Administrator:_____
Laboratory Director (If Applicable):_____
Facility E-Mail Address_____
Days And Hours Of Operation:_____

OWNERSHIP

a. Type of ownership:

Association:	☐	Partnership:	☐
Corporation:	☐	Other (explain):	☐
Individual:	☐	Limited Liability Co.	☐

Please provide the following information or attached copies of documents.

b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility.

c. If the licensee is organized as an association, corporation or limited liability company (LLC) list the name of the corporation or association and the name, address and title of each officer.

d. If the licensee is a partnership, list the name(s) and address(es) of all the partners.

FEES:	Collecting Stations	$50.00 per year
	Laboratories	$65.00 per category of testing

A check or money order (payable to: **STATE OF NEW HAMPSHIRE, TREASURER)**, must be attached to this application.

APPLICATION FOR NEW LICENSE

1. Be submitted at least 120 days prior to opening the new facility.

2. Submit a floor plan of the facility

3. Attach qualifications, including education, experience and copies of all applicable licenses for the administrator or laboratory director (if applicable).

4. A copy of one of the following documents, providing proof of authorization to do business in New Hampshire, from the New Hampshire secretary of state:
    a. "Certificate of Authority," if a corporation;
    b. "Certificate of Formation," if a limited liability company; or
    c. "Certificate of Trade Name," if a sole proprietorship;

5. A written disclosure from the owner(s) and the laboratory director containing:
    a. A list of any felon convictions; and
    b. An explanation of the circumstances surrounding any felony convictions.

APPLICATION FOR LICENSE RENEWAL SHALL:

1. Be submitted at least 120 days prior to expiration of the current license.

2. A written disclosure from the owner(s) and the laboratory director containing:
    a. A list of any felon convictions; and
    b. An explanation of the circumstances surrounding any felony convictions.

3. Attach qualifications, including education, experience and copies of all applicable licenses for the administrator, medical director or laboratory director (if applicable).

4. Include information relative to whether the facility has been granted any waiver and/or exemptions to the rules by the Commissioner of the Department of Health and Human Services and/or the State Fire Marshal.

FACILITY SERVICE DESCRIPTION:

The following information will be used to determine which licensure category your facility shall be placed in.

I. Provide a detailed description of the services you wish to provide.

II. Please indicate which laboratory categories you will be testing:

☐	Microbiology	☐	Diagnostic immunology
☐	Chemistry	☐	Hematology
☐	Immunohematology	☐	Pathology
☐	Radiobiasassay	☐	Clinical cytogenetics

SIGNATURES:

This application must be signed by:

1. The owner if a private facility;
2. 2 officers if a corporation;
3. 2 authorized individuals if an association or partnership;
4. The head of the government department if a government unit.

I affirm that I am familiar with the requirements of RSA 151 and the rules adopted thereunder and that the premises are in full compliance. I understand that providing false information shall be grounds for denial, suspension, or revocation of a license, or imposition of a fine.

Date: _____ Signed: _____
(Name and Title)

_____
Print Name and Title

Date: _____ Signed: _____
(Name and Title)

_____
Print Name and Title

CHECK NUMBER: _____ AMOUNT: _____

APPLICATION COMPLETE: _____ NOT COMPLETE: _____
(Describe in comments)

Certificate of Need:	Required	☐	Not Required	☐	Received	☐
Local Approval:	Required	☐	Not Required	☐	Received	☐
LSC Inspection:	Required	☐	Not Required	☐	Received	☐
LSC Plan of Correction:	Required	☐	Not Required	☐	Received	☐
Licensure Inspection:	Required	☐	Not Required	☐	Received	☐
Plan of Correction:	Required	☐	Not Required	☐	Received	☐
Water Testing Information	Required	☐	Not Required	☐	Received	☐
Floor Plan	Required	☐	Not Required	☐	Received	☐

Federal Facility (Exempt From Inspection) YES ☐ NO ☐

LICENSURE CATEGORY:

☐	02	General Hospital	☐	17	Collecting Station
☐	03	Nursing Facility	☐	18	Adult Day Care Provider
☐	04	Residential Care Home Fac	☐	19	Case Management Services
☐	05	Supported Residential Care Fac	☐	21	Equipment Management
☐	06	Outpatient Clinic	☐	22	Homemaker Provider
☐	07	Residential Treatment Rehab Fac	☐	23	Hospice Care Provider
☐	08	Laboratory	☐	24	Hospice House
☐	09	Home Health Care Provider	☐	25	Special Hospital - Substance Abuse
☐	10	Birthing Center	☐	26	Special Hospital – Psychiatric
☐	11	End Stage Renal Dialysis Ctr	☐	27	Special Hospital - Rehabilitation
☐	12	Ambulatory Surgical Facility Psychiatric	☐	28	Freestanding Hosp Emergency Fac
☐	14	Community Residence DD	☐	29	Hlth Promo, Disease Prev & Screen
☐	15	Community Residence -BH	☐	30	Acute Psych Rehabilitation Facility
☐	16	Educational Health Center	☐	31	Neurobehavioral RTRF

Reviewed By: _____
(Name & Title) (Date)

Issue Annual License: YES _____ NO _____

License Certificate Dates: From _____ To _____

Notes:

Comments On Certificate: